

Name: _____

Date: _____

Mailing address or e-mail: _____

Phone: _____

HEADACHES

Please mark the description(s) that best describe your symptoms

LOCATION OF PAIN

<input type="checkbox"/> Top of the head	<input type="checkbox"/> One side only	<input type="checkbox"/> Temples	<input type="checkbox"/> Behind the eyes
<input type="checkbox"/> Forehead	<input type="checkbox"/> Back of head (occiput)	<input type="checkbox"/> Whole Head	<input type="checkbox"/> Changing location

TYPE OF PAIN

<input type="checkbox"/> Sudden onset	<input type="checkbox"/> Gradual onset
<input type="checkbox"/> Dull <input type="checkbox"/> Heaviness and congestion as if wrapped in a cloth <input type="checkbox"/> Difficulty concentrating and thinking in the morning <input type="checkbox"/> Dizziness and blurred vision	<input type="checkbox"/> Sharp
<input type="checkbox"/> Distending <input type="checkbox"/> Throbbing or pulsating <input type="checkbox"/> Affects one or both sides of the head <input type="checkbox"/> Whole head feels distended	<input type="checkbox"/> Chronic, with stiff neck and shoulders <input type="checkbox"/> Acute occipital stiffness
<input type="checkbox"/> Pulling sensation	<input type="checkbox"/> Intense, fixed, stabbing pain
<input type="checkbox"/> Sensation of emptiness of the brain	

BETTER WITH:

<input type="checkbox"/> Pressure	<input type="checkbox"/> Activity	<input type="checkbox"/> Rest	<input type="checkbox"/> Lying down	<input type="checkbox"/> Eating
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WORSE WITH:

<input type="checkbox"/> Pressure	<input type="checkbox"/> Activity	<input type="checkbox"/> Rest	<input type="checkbox"/> Lying down	<input type="checkbox"/> Eating
<input type="checkbox"/> Heat	<input type="checkbox"/> Cold	<input type="checkbox"/> Damp	<input type="checkbox"/> Day	<input type="checkbox"/> Night
<input type="checkbox"/> Anger	<input type="checkbox"/> Excitement	<input type="checkbox"/> Worry	<input type="checkbox"/> Fear	<input type="checkbox"/> Relaxing during weekend
<input type="checkbox"/> Pre-menstrual	<input type="checkbox"/> During menses	<input type="checkbox"/> Post-menstrual	<input type="checkbox"/> Excess Sex	<input type="checkbox"/> Overwork

ACCOMPANYING SYMPTOMS:

<input type="checkbox"/> Numbness <input type="checkbox"/> Twitching <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Shoulder and neck tension after exposure to wind and cold	<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Inflammation <input type="checkbox"/> Eye and ear infections <input type="checkbox"/> Skin eruptions <input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Stabbing pain <input type="checkbox"/> Chest pain <input type="checkbox"/> Chronic insomnia	<input type="checkbox"/> Joint pain <input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Insomnia <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Drug withdrawal <input type="checkbox"/> Constipation	<input type="checkbox"/> Acute pain <input type="checkbox"/> Digestive symptoms <input type="checkbox"/> Loose stools <input type="checkbox"/> Vomiting <input type="checkbox"/> Cramping	<input type="checkbox"/> Pre-menses <input type="checkbox"/> PMS <input type="checkbox"/> Emotional tension
<input type="checkbox"/> Post-menses <input type="checkbox"/> Scant menses <input type="checkbox"/> Pale complexion <input type="checkbox"/> weakness	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Digestive disturbance
<input type="checkbox"/> Hypertension		

RETURN COMPLETED FORM TO: Harmony Gate Wellness Center, LLC. 224 Silver Bluff Rd. Aiken, SC 29803. Phone: (803) 649-4047

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